INDEPENDENCE DAY

Will Gordon Brown as prime minister give independence to the NHS, and is it such a winning idea anyway? **Nigel Hawkes** investigates

Politicians seldom admit that their presence may not be strictly necessary. But the debate over NHS independence, launched in the *BMJ* in 2006, has inspired some soul searching. Has political meddling held back progress or interfered with the ability of medical professionals to deliver the best possible service for the money? Might an independent NHS, shorn of day to day management by ministers, work more smoothly and harmoniously?

Among those in favour of the proposition are David Cameron and Andrew Lansley of the Conservative party, the Council of the BMA, policy analyst Chris Ham of the University of Birmingham, top NHS manager Mark Britnell, and Gordon Brown.

Among those against are Tony Blair, Alan Milburn, the health minister Andy Burnham, John Appleby of the King's Fund, Nigel Edwards of the NHS Confederation, and Gordon Brown.

The future prime minister's presence on both lists is no accident. He famously likes to keep his ideas to himself and a small group of confidants and has (so far as I can establish) never expressed a view on the issue in a speech or article. But he has "let it be known," first before the 2006 Labour conference, that he favoured NHS independence[1] and then in May this year that he does not.[2] Neither of these expressions of opinion was more than a nod and a wink to journalists, so we really do not know what Mr Brown thinks. That's the way he likes it.

However, it was Mr Brown who, without advance warning, gave the Bank of England independence to set interest rates, and this precedent has fuelled the speculation. The fact that Mr Blair went out of his way to criticise independence for the NHS at a recent breakfast organised by the King's Fund makes conspiracy theorists more convinced that Mr Brown favours it. But I doubt Mr Blair has any more idea what Mr Brown is thinking than the rest of us do.

There is nothing the NHS commentariat likes better than a newish idea to chew over. Discussions of structure tend to dominate discourse about the NHS, says Nigel Edwards, and this is yet another example. He sees these discussions as a kind of displacement activity by people unable to do much to change what is happening on the ground.

Weighing the arguments

The most substantial effort so far to put flesh on the bones of NHS independence is

ANDREW PARSONS/AP/PA

PROPOSED MODELS FOR AN INDEPENDENT NHS[3]

Modernised NHS Executive within the Department of Health—designed to separate policy from delivery. Not very radical but it might be a stepping stone to more sweeping changes later

NHS Commissioning Authority—modelled on the Higher Education Funding Council for England and operating as a non-departmental public body at arm's length from ministers. Its job would be to develop commissioning skills, and it would fit easily into the current NHS pattern, with primary care trusts acting as its local delivery arms

NHS Corporation—a fully managed national service on the BBC model comprising all publicly owned assets, including foundation trusts. This is what most people imagine an independent NHS would be like, reminiscent in some respects of an old style industry

NHS Corporation limited to planning, commissioning, and inspecting NHS services— provided with its own charter, it would be more powerful than a commissioning authority but there are questions about how much can be achieved by better commissioning and how long it would take

Regionalised NHS—the NHS would be run by independent regions that could be non-departmental public bodies or public corporations. Might work best if England ever moved to regional government

NHS commissioned by local government—local authorities have responsibility for commissioning care. This model could be trialled in a big city and the results independently evaluated

NHS as a public insurance company—the NHS would be defined as an insurance company funded by taxation and would licence other organisations to commission health services. This could introduce competition as the licensed organisations—primary care trusts, general practitioners, insurance companies, large employers, or trade unions—could compete to provide best access to health care through providers with whom they struck deals. A radical change, though not outside the founding principles of the NHS

published this week by the Nuffield Trust.[3] The trust asked Brian Edwards, emeritus professor of Healthcare Development at the University of Sheffield, to look at the options. His experience includes a spell on the NHS Executive in the 1990s, an earlier attempt by the Conservatives to introduce a degree of independence into the NHS. The executive lacked the space or the authority to work well and was abandoned.

Since then more models have emerged to consider. Bank of England independence is an imperfect example because it covers only a single monthly decision, albeit an important one. The NHS involves millions of decisions every day. Better examples are the new BBC governance arrangements and the Higher Education Funding Council, which is given the money to support the universities and then left to its own devices.

But discussion has to start, Professor Edwards's report says, from the recognition that a large and growing part of the NHS is already independent—foundation trusts. Under the law that established them, they are explicitly excluded from the list of bodies to which a secretary of state can issue a directive. Primary care, too, is provided by independent practitioners under contract to primary care trusts.

That means that within a short time only the policy and commissioning arms of the NHS, a few remaining NHS trusts that have failed to secure foundation status, and the residue of directly managed community services will remain under ministerial control. It is these functions that the independence debate must focus on, short of new legislation to abolish the purchaser-provider split and renationalise the foundation trusts.

Professor Edwards summarises the pros and cons swiftly. One advantage for the creation of an independent NHS authority is "the ability to create distance from the heat of political battle." Such a body might find it easier to open up to public and professional debate, conducting most of its business in public and cultivating a managerial rather than a political culture. But for it to be worth while it would have to offer more than a political screen; it would have to provide a credible and powerful platform for the modernisation of the NHS.

On the other side there are arguments over the need for ministers to control a budget that now approaches £100bn (€147bn; $197bn) a year, and for parliament to be accountable for how that money is spent. And without politicians in charge, who will drive the change in what would otherwise be a professionally dominated organisation? This was the argument used by Tony Blair.

"If it is a way of making decisions, I can understand the point of it" he said.[4] "My worry is if it became a means of avoiding decisions. Someone has to take the decisions if it is a driving force for change, rather than a brake on it."

How could it work?

Professor Edwards looks at seven potential models for an NHS authority, ranging from a modest strengthening of the NHS Executive at one extreme to a model where the government retains responsibility for funding and major priorities but little else (box). In most models, independence would need to be accompanied by the creation of an independent regulator, occupying the same role that Monitor does for the foundation trusts. The NHS authority would make decisions at arm's length from the political process. But those decisions would be subject to appeal to the regulator, with a judicial review to follow if there were questions over procedure.

There would also need to be rules, or what the BMA in its contribution to the debate calls an NHS constitution. In the BMA version this would enshrine the core values of the service—what the public could expect from it and what would be expected from them—and outline the arrangements to determine what services would be

available.[5] The BMA envisages an NHS board of governors appointed by parliament, an executive management board appointed by the governors, greater clinical engagement with professionals, and a move away from the purchaser-provider split.

The Conservative party is also working on its own proposals, to be published soon as an NHS independence bill. Details are scanty, but shadow health secretary Andrew Lansley has said that the creation of an independent NHS board would ensure equality of access to health care, prevent political manipulation of the NHS, and secure improving standards.[6] It would sit alongside an economic and a quality regulator and be underpinned by an independent, statutory voice for patients.

These declarations of independence have sharply divided commentators. There are some, such as the Birmingham group led by Chris Ham, a former director of strategy at the Department of Health, who back them strongly. A recent paper from the group, *Things Can Only Get Better?*, argues that the current system allows politicians to overstep their democratic mandate and to intervene in the NHS in a way that damages the service and the politicians themselves. "This has probably been the case for some time but has now got so bad that it is time for a decisive change" they argue.[7]

But John Appleby and Nigel Edwards disagree. In a recent interview Professor Appleby said: "The closer you look at it [NHS independence], the more it tends to fall apart. Where this falls down is frankly that it is public money. Politicians cannot disengage. Who do we hold responsible? It's not obvious what independence would mean. The government made a very specific task of the Bank of England independent. What's the health equivalent?"[8]

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Nigel Edwards says that the idea is quite attractive at first sight, because it would eliminate short termism and reduce the instinct to meddle. "But when you look at it, problems emerge" he says.

He cites the cases of Poland and Hungary, two countries that set up social insurance models of health care, at arm's length from politicians but reporting to parliament. "They have lost public accountability, without any real gain," he suggests. "The people who want to change the system don't have the levers to do it, while the people who have the levers don't want to change it." Independence from political control tends, in his view, to be a vote for stasis—for doing nothing.

"This experience isn't very encouraging," he says. "It doesn't insulate ministers from criticism, and they are in an even worse situation than before. They are criticised whatever happens, with no power to put it right."

He also warns that devolving power to a board could stop further devolution to local bodies. This has already happened in Wales since control of the NHS went to the devolved assembly.

Mr Edwards' views are shared by the former health secretary, Alan Milburn. He said that people looking for more change at the top of the NHS "are searching at the wrong end of the system."[9] Calling the idea "a masquerade," he said the fixation should be less with structures and more with greater choice for patients over care, and over how the money is spent.

Andy Burnham, the health minister, put it more strongly in comments quoted by the *Observer*.[2] "The era of top-down, centrally-driven targets is coming to an end," he said. "An independent, central board running the NHS would replicate the same top-down approach but with less accountable people running the NHS."

But Mark Britnell, chief executive of NHS South Central, says that current fashion for devolution and decentralisation is not new—it has been tried before and failed.[10] His experience of being chief executive of a foundation trust, University Hospital Birmingham, has convinced him that independence has great merits.

"Staff feel more accountable for solutions and you certainly cannot blame your performance on anybody else," he says. "The difference is that you have legal power and autonomy and, while critics might argue that these freedoms have not been rapidly capitalised on, they are very real and give you a different outlook."

Recent internal reorganisation at the NHS has led some to suggest that the chief executive, David Nicholson, is preparing the ground for independence. But in a speech to the Institute of Healthcare Managers in Harrogate in May, he knocked this idea on its head. "There has to be democratic accountability when it comes to the spending of £90 billion of tax payers' money" he said. "The involvement of politicians, contrary to popular perception, is not a hindrance to the NHS, it gives us legitimacy and they are crucial to securing us the funding."

Professor Edwards found that few people he spoke to when writing his report have any appetite for further major structural changes in the NHS. Views on independence polarised into two distinct camps: those who regard it as unthinkable that any organisation as large as the NHS and spending so much public money could realistically become independent, and those who believe that the way to improve the NHS is to stop politicians meddling in its management. No consensus emerged. All we can do is wait and see if Mr Brown will surprise us, as he did the financial markets in 1997. My instinct is that he won't.

Nigel Hawkes is health editor, the *Times*
nigel.hawkes@thetimes.co.uk

Competing interests: None declared.

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